STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 4/8/19 through 4/12/19. The facility was found in complaince with the requirement CFR 483.73, Emergency Preparedness. Event ID # PRBP11.	E 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);	F 584		5/10/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/09/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 1 §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain a clean splinting device for 1 (Resident #14) of 3 residents reviewed for limited range of motion. Findings included: Resident #14 was admitted to the facility on 3/3/15 with diagnoses, in part, of hemiplegia and cerebrovascular accident. A review of a quarterly Minimum Data Set (MDS) assessment dated 1/17/19 revealed Resident #14 required extensive assistance with 2 people for bed mobility and transfers, extensive assistance with one person for dressing, toileting and bathing. Resident #14 required minimal assistance with meals. He had a functional limitation in range of motion in his upper extremity on one side. A review of the care plan updated on 2/20/19 revealed resident #14 required restorative care; splinting. Intervention was to apply right resting hand splint after morning care for 6-8 hours as tolerated for contractures.	F 584	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice •Splint for Resident #14 was inspected by the Area Therapy Director on 4/12/19 and was found to be clean and in good repair. Splint will be inspected daily by the Restorative Nurse Aide (RNA) prior to application and nursing staff will remove and clean if found to be dirty. RNA will clean the splint if needed and notify the Therapy Program Manager if the splint is no longer in good repair. Address the facility will identify other residents having the potential to be affected by the same deficient practice: •A 100% audit was conducted of splints by the Therapy Program Manager on 5/3/19 and all splints were found to be clean and in good repair. All splints will be inspected by restorative nursing aide for cleanliness prior to application. Dirty braces/splints will be cleaned prior to application. Address what measures will be put into	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 2 An observation on 4/11/19 at 9:31 AM revealed Resident #14 out of bed to his wheelchair in his room. A right hand splint was observed on Resident #14 ' s dresser. The splint was observed to be visibly soiled in the area where the thumb rests and the straps that secure the splint to the resident ' s hand. A follow up observation was made on 4/11/19 at 1:56 PM. Resident #14 was out of bed in his wheelchair watching television in his room. Resident #14 had a splint in place to his right hand. The splint remained visibly soiled under Resident #14 ' s thumb and on the straps that secure the splint to the resident ' s hand. An interview was conducted with Nursing Assistant (NA) #1 on 4/11/19 at 2:42 PM. NA#1 revealed the restorative nursing assistant applies the splints and removes them. An interview was conducted with Restorative Aide (RA) #1 on 4/11/19 at 2:58 PM. RA#1 revealed she applied the splint to Resident #14 ' s right hand today. She stated either restorative staff or the second shift nursing assistants remove the splints and clean them and allow them to air dry. She stated the splint should not be applied if it is soiled. She observed the splint on Resident #14 ' s right hand at this time and stated it didn ' t look like it had been cleaned. RA #1 revealed she should ensure the splint was clean prior to applying. An interview was conducted with the Therapy Manager on 4/11/19 at 3:19 PM. She stated she also manages the Restorative Program. She revealed the restorative aides apply the splints and if they are visibly soiled, they should be	F 584	place or systemic changes made to ensure that the deficient practice will not recur •The RNAs were in-serviced on 5/2/19 by the Therapy Program Manager to inspect splints prior to application and upon removal for cleanliness and good repair. Soiled braces/splints will be sent to laundry in the facility. A second brace/splint will be purchased for those residents whose braces/splints are becoming soiled from independent eating activities RNAs were instructed to clean any splints found to be dirty. •CNAs will be in-serviced by 5/10/19 to notice and remove dirty splints if identified. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained •Therapy Program Manager (TPM) will audit the splints weekly for cleanliness and good repair. TPM will immediately address any concerns identified during her audit. Audits will be conducted by the TPM/designee weekly x4 weeks, monthly x 3 months, and as needed to ensure compliance. •Audit Compliance will be discussed weekly by the TPM/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. •QA Members will randomly inspect the resident and their room weekly to ensure splints and other equipment are clean and in good repair. Audits will be turned into	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 3 cleaned prior to use. An interview was conducted with the Director of Nursing on 4/12/19 at 2:00 PM. She revealed her expectation was for splints to be clean prior to use.	F 584	the facility administrator for review. •The TPM/designee will bring results of the splint audit at the facility monthly QA meetings for committee review and input monthly X 3 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the TPM/designee and monitoring to begin again at the weekly audits until compliance is met. The Therapy Manager is responsible for the implementation of this plan.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set-a tool used for resident assessment) for 4 of 25 residents records reviewed (Resident #16, Resident #33, Resident #50, and Resident #83). Findings included: 1. Resident #16 was admitted to the facility 8/28/17 and re-admitted 2/21/18. A review of a quarterly MDS dated 3/26/19 revealed Resident #16 was severely cognitively impaired, required total assistance for all activities of daily living except eating, had both lower limbs impaired, and	F 641	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice •Resident #16 MDS assessment was corrected and transmitted with the chemotherapy drug. •Resident #33 MDS assessment and care plan was updated to accurately reflect mouth caries, mouth pain, and side rails as a positioning device and not a restraint. •Resident #50 MDS assessment and care plan was updated to accurately reflect the side rails as a positioning device and not a restraint.	5/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 4 was frequently incontinent. Active diagnoses included multiple myeloma (a type of blood cancer) without remission, malignant neoplasm (cancer) of the right breast, malignant neoplasm bone, and chronic kidney disease. The special treatments and procedures section of the MDS was coded "No" for Resident #16 having had received chemotherapy while a resident. Care plans last updated 3/26/19 for Resident #16 revealed a care plan, which read, in part, "Resident is receiving radiation/chemotherapy treatment for cancer." The stated goals included "resident will not experience unmanageable side effects from treatment over the next 90 days." Interventions included "evaluate response to the treatment after each session, provide with anti-emetic (a medication used to prevent vomiting) medications as needed, and allow rest periods throughout the day as needed." Physician orders dated 3/1/19 through 3/31/2019 included orders for: Revlimid (a drug used to treat multiple myeloma) 5mg (milligram) capsule, and Femara (a drug used to treat breast cancer in post-menopausal women) 2.5mg tablet. Review of the MAR (Medication Administration Record) dated 3/1/19 through 3/31/19 revealed Resident #16 received Revlimid 5mg 3/16/19 through 3/31/19 with no missed doses, and Femara 2.5mg every day of March 2019. An interview with Nurse #1 on 4/11/19 at 8:30AM revealed Resident #16 had active diagnoses which included breast cancer, multiple myeloma, and bone cancer. She stated Resident #16 was taking a chemotherapy medication by mouth until 4/10/19.	F 641	•Resident #83, MDS assessment and care plan was updated to accurately reflect dialysis schedule on Monday, Wednesday, and Friday. Address the facility will identify other residents having the potential to be affected by the same deficient practice: •A 100% audit was conducted of assessments by the Director of Clinical Reimbursement (DCR) on all assessments transmitted since 4/12/19 to ensure that the assessment must accurately reflect the resident's status by 5/10/19. •Any inaccuracies identified on the assessments during the audit were corrected by the DCR/designee. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur •The facility has a full-time RN in the MDS Coordinator position effective 5/9/19. •The RN MDS Coordinator will ensure that assessments accurately reflect the resident's status. •The MDS coordinator, MDS assistant, and interim Director of Nursing Service received in-service training by the DCR on the MDS Coordinator requirements to ensure compliance with MDS accuracy on 4/30/19. •The MDS coordinator will participate in daily administrative nurse meetings to ensure that as interventions and changes are made, they are immediately transcribed to the careplan and updated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5 An interview was conducted on 4/11/19 at 8:45AM with MDS Nurse #1. She stated, "I'm familiar with (Resident #16). Her active diagnoses included multiple myeloma (a type of cancer), and breast and bone cancer. She receives Revlimid, a medication used to slow multiple myeloma symptoms and stops the growth of cancer cells. She was going out to get chemo (chemotherapy). The last time she went out was 3/21/19. She was getting chemo every 2 weeks. Section "O" (Special Treatments and Procedures) is where chemotherapy is coded, but it's not coded for (Resident #16). She also takes Femara for breast cancer. It's a medication used to treat breast cancer in post-menopausal women. If medications are classified as chemotherapy drugs Section "O" should be coded as chemotherapy. But when I looked up Revlimid it didn't say chemotherapy drug." An interview was conducted with the Director of Nursing on 4/11/19 at 9:20AM. She stated, "(Resident #16) is on Revlimid which helps her symptoms and is part of her chemotherapy plan. She also takes Femara as part of her chemotherapy plan. Her Oncologist prescribed it. She stopped taking it 4/4/19. She started it 3/16/19. My expectation for MDS accuracy is for it to be coded accurately." An interview was conducted with the Consultant Pharmacist on 4/11/19 at 9:40AM. She stated Revlimid is a chemotherapy agent. She stated, "It's an anti-neoplastic agent." She also stated Femara is an anti-neoplastic agent (chemotherapy drug) used to treat breast cancer in post-menopausal women. She stated Resident #16 received both medications from 3/19/19	F 641	on the next scheduled MDS assessment. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained •An audit tool titled MDS Coordination/Certification and Accuracy Audit, has been developed to monitor performance. Audits will be conducted by the DCR/designee weekly x4 weeks, monthly x 3 months, and as needed to ensure compliance with accuracy. •Audit Compliance will be discussed weekly by the ED/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. •The ED/designee will bring results of MDS Coordination/Certification and Accuracy Audit at the facility monthly QA meetings for committee review and input monthly X 3 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DCR/designee and monitoring to begin again at the weekly audits until compliance is met. The Executive Director is responsible for the implementation of this plan.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 6	F 641		

through 3/31/19.

2. Resident #33 was admitted to the facility 12/13/2018 with diagnoses to include pulmonary disease, congestive heart failure and gout. A review of the admission Minimum Data Set (MDS) assessment dated 12/19/2018 assessed Resident #33 to be cognitively intact without behaviors or rejection of care.

A. The Oral/Dental Status section of the MDS was reviewed and revealed no obvious or likely cavities, no loose natural teeth, no mouth or facial pain and no discomfort or difficulty chewing. Resident #33 was observed on 4/9/2019 at 11:25 AM and he was missing all teeth on his top jaw and had darkened and pitted teeth on the bottom jaw.

Resident #33 was interviewed on 4/11/2019 at 4:40 PM and reported mouth pain on the left side of the lower jaw and only had 6 teeth, 3 on each side of the lower jaw. He further reported he was able to chew food by avoiding chewing on the left side.

MDS Nurse #1 was interviewed on 4/12/2019 at 11:56 AM and she reported she visited with Resident #33 every day and he had not complained of mouth pain to her and she had not noticed his missing teeth or tooth decay. MDS Nurse #1 further reported she had not completed Resident #33 ' s admission MDS and the nurse who did was no longer working at the facility.

The Director of Clinical Operations was interviewed on 4/12/2019 at 1:32 PM and she reported it was her expectation the MDS assessment was coded correctly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 7	F 641		

B. An occupational therapy note dated 12/14/2018 documented Resident #33 had limited range of motion of his left and right shoulder.

A review of the admission MDS assessment dated 12/19/2018 coded Resident #33 to have "impairment on both sides" upper body range of motion.

The Quarterly MDS assessment for Resident #33 dated 1/25/2019 was coded as "0-none" for limb impairment of upper body range of motion.

Resident #33 was observed on 4/9/2019 at 11:15 AM. He was unable to lift his left or right arm above his head.

An interview was conducted with Resident #33 on 4/9/2019 at 11:15 AM. He reported he had limited range of motion of both shoulders.

The Rehabilitation Program Director (RPD) was interviewed on 4/11/2019 at 4:46 PM. The RPD reported Resident #33 had been treated by occupational therapy for functional mobility, dressing and toileting and Resident #33 was noted to have limited range of motion of both shoulders, as well as impaired strength.

The MDS Nurse #1 was interviewed on 4/12/2019 at 11:56 AM and she reported she visited with Resident #33 every day and had not noticed he had limited range of motion of his shoulders. The Director of Clinical Operations was interviewed on 4/12/2019 at 1:32 PM and she reported it was her expectation the MDS assessment was coded correctly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 8	F 641		

C. The Quarterly MDS assessment for Resident #33 dated 1/25/2019 revealed bed rails were not used and "other" types of restraints were used daily.

Resident #33 was observed on 4/9/2019 at 11:15 AM in bed. He had ¼ upper side rails on his bed and both sides were up.

An interview was conducted with Resident #33 on 4/9/2019 at 11:15 AM. He reported he used the side rails to assist him to transfer in and out of bed and the rails did not prevent him from exiting the bed.

Nursing assistant (NA) #2 was interviewed on 4/10/2019 at 4:18 PM and she reported Resident #33 used the side rails on his bed to assist with stability to transfer from his wheelchair into his bed.
An interview was conducted with NA #3 on 4/11/2019 at 3:23 PM and she reported the side rails on Resident #33 ' s bed assisted him to transfer.

MDS Nurse #1 was interviewed on 4/12/2019 at 1:30 PM and she reported she thought bed rails were coded as restraints for all residents.

The Director of Clinical Operations was interviewed on 4/12/2019 at 1:32 PM and she reported it was her expectation the MDS assessment was coded correctly.

3. Resident #50 was admitted to the facility 4/15/2014 and readmitted 9/18/2018 with diagnoses to include pneumonia, chronic kidney disease and congestive heart failure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 9	F 641		

The Quarterly MDS assessment for Resident #50 revealed bed rails were not used and "other" types of restraints were used daily.

The annual MDS assessment dated 4/2/2019 assessed Resident #50 to be cognitively intact without behaviors and she required extensive 2-person assistance with bed mobility.
Resident #50 was observed on 4/8/2019 at 6:04 PM in bed. She had ¼ side rails on her bed and both sides were up.

An interview was conducted on 4/8/2019 at 6:04 PM with Resident #50. She reported the side rails were to assist her with bed positioning and provided her with a place to grip when she was turning in bed.

Nursing assistant (NA) #2 was interviewed on 4/10/2019 at 4:18 PM. NA #2 reported Resident #50 required 2-person assistance to turn and reposition in bed, but she had side rails to assist her with turning.

NA #5 was interviewed on 4/11/2019 at 3:59 PM and he reported Resident #50 required 2-person assistance with bed mobility and the side rails assisted her to turn in bed.

An interview was conducted with NA #6 on 4/11/2019 at 4:00 PM and she reported Resident #50 had side rails on her bed to assist with bed positioning.

MDS Nurse #1 was interviewed on 4/12/2019 at 1:30 PM and she reported she thought bed rails were coded as restraints for all residents.

The Director of Clinical Operations was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 10	F 641		

interviewed on 4/12/2019 at 1:32 PM and she reported it was her expectation the MDS assessment was coded correctly.

4. Resident # 83 was re-admitted to the facility on 2/20/19 with diagnoses of, in part, end stage renal disease and dependence on renal dialysis.

A review of Resident #83's Quarterly Minimum Data Set (MDS) assessment dated 3/4/19 did not reflect Resident #83 was receiving dialysis.

A review of the physician's orders revealed an order for dialysis on Monday, Wednesday and Friday.
An interview was conducted with Nurse #4 on 4/11/19 at 2:40 PM. She revealed Resident #83 had been on dialysis for a long time and went to dialysis on Monday, Wednesday and Friday.

An interview was conducted with the Corporate Director of Operations, on 4/11/19 at 9:20AM. She stated, "We assess residents through observations, electronic medical record review, hospital and physician notes and staff interviews. Once you assess and gather information you complete the MDS accurately and timely. Resident care plans are developed from there. We also do baseline care plans within 48 hours. We've been bringing in RN's (Registered Nurses) to help with MDS. Our SDC nurse (Staff Development Coordinator) is transitioning to MDS next week."

An interview was conducted with MDS Nurse #1 on 4/11/19 at 3:35 PM. She revealed she is currently completing MDS's for the whole building. She stated dialysis should have been coded on Resident #83's quarterly MDS, but she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 11 missed it.	F 641		
F 642 SS=D	Coordination/Certification of Assessment CFR(s): 483.20(h)-(j) §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1)Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to close and transmit 3 of 3 discharged residents (Resident #1, #2 and #3) MDS (Minimum Data Set-a tool used for resident assessment) within 120 days.	F 642	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice •Assessments for Resident #1 and	5/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 642	Continued From page 12 Findings included: 1. Resident #1 was discharged 11/14/18. The discharge assessment was completed by MDS Nurse #1, but was not signed as completed by a registered nurse (RN) so it remained open and un-transmitted on 4/12/19. 2. Resident #2 was discharged 11/27/18. The discharge assessment was completed by MDS Nurse #1, but was not signed as completed by a registered nurse (RN) so it remained open and un-transmitted on 4/12/19. 3. Resident #3 was discharged 12/27/18. The discharge assessment was completed by MDS Nurse #1, but was not signed as completed by a registered nurse (RN) so it remained open and un-transmitted on 4/12/19. An interview was conducted on 4/11/19 at 2:55PM with the Administrator, Director of Clinical Operations, and the Clinical Nurse Consultant. The Administrator stated, "We're without an MDS RN currently. We had one until January 2019, and then another one from January 2019 through 3/13/19. Since 3/13/19 other MDS RNs have come in from other facilities to help (MDS Nurse #1). The Director of Clinical Operations stated she could not give a reason why these 3 discharge MDSs were not signed without speaking to her 'expert', or the former MDS nurse. An interview was conducted on 4/11/19 at 4:05PM with the Director of Clinical Reimbursement Services. She stated, "I am an RN. I come to the facility at least once weekly. I	F 642	Resident #2 was signed by the Corporate RN consultant on 4/18/19 and transmitted. Resident #3 was signed and transmitted on 5/9/19. •Resident #1, Resident #2, and Resident #3 have been discharged from the facility. Address the facility will identify other residents having the potential to be affected by the same deficient practice: •A 100% audit was conducted of assessments by the Director of Clinical Reimbursement Services on all assessments completed 120 days prior to 4/12/19 to ensure that the following requirements were met: 1) a registered nurse had signed and certified that the assessment was completed 2) assessments were closed and transmitted. •Any assessments identified during the audit were corrected by the DCS. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur •The facility has a full-time RN in the MDS Coordinator position effective 5/9/19. •The RN MDS Coordinator will ensure that assessments are signed, closed, and transmitted according to the state rules and regulations. •The MDS coordinator, MDS assistant and interim Director of Nursing Service received in-service training on the requirements of coordination/certification of assessment by the DCR on 4/30/19.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 642	Continued From page 13 function as the MDS Coordinator and do all the education on MDS for them. We currently don't have an RN in that job. Those 3 MDSs that weren't signed I cannot say why they weren't signed. After (MDS Nurse #1) completed them she would give a list to (MDS Nurse #3) and she would sign them as complete. But as far as knowing why those three were missed I don't know why. They should have been signed and closed in a timely fashion because we had an RN in the building full time at that time."	F 642	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained •An audit tool titled MDS Coordination/Certification and Accuracy Audit, has been developed to monitor performance. Audits will be conducted by the DCR/designee weekly x4 weeks, monthly x 3 months, and as needed to ensure compliance with the coordination/certification of assessment. •Audit Compliance will be discussed weekly by the ED/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. •The ED/designee will bring results of MDS Coordination/Certification and Accuracy Audit at the facility monthly QA meetings for committee review and input monthly X 3 months, and as needed. All discussion will be maintained in meeting minute notes. Any non-compliance will be noted and corrective actions taken. Any change to the monitoring plan will require re-in servicing by the DNS/designee and monitoring to begin again at the weekly audits until compliance is met. The Executive Director is responsible for the implementation of this plan.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657		5/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 14 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to review the care plan following the 2/18/19 minimum data set assessment and failed to revise the interventions of the care plan of 1 of 25 sampled residents. The care plan interventions did not include the discontinued use of the communication board and an unsupervised appointment visit (Resident #46). Findings included:	F 657	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice *For Resident #46: Care plan meeting was held on 4/24/19 to include and advise the resident of any changes in the plan of care. Family was invited on 4/8/19 but did not participate. Resident #46 and applicable members of the IDT (Interdisciplinary Team) were in attendance for this meeting. Resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 15 Resident #46 admitted to the facility on 12/5/17 with diagnoses which included: hemiplegia following cerebral infarction affecting the right dominant side, vascular dementia with behavioral disturbance, aphasia, dysphagia, diabetes mellitus, glaucoma, and unsteadiness on his feet. Review of the quarterly minimum data set dated 2/18/19 indicated Resident #46 had short-term and long-term memory problems with moderately impaired decision-making skills. The review of Resident #46's signature page of the care plan revealed the most recent facility review of the care plan was on 11/19/18. Also, the care plan's interventions were not revised to address the issue of the resident traveling to appointments without supervision of facility staff or family member; and the resident's refusal to use the communication board. During an observation on 4/09/19 at 11:57 a.m., Resident #46 was unable to communicate verbally but was able to communicate with hand gestures and facial expressions. During an interview on 4/11/19 at 11:02 a.m., Nurse#4 stated that Resident #46 was alert but non-verbal and unable to make safe decisions. She revealed the resident did not use a communication board but was able to use hand gestures and nod his head when as a form of communication. During an interview on 4/11/19 at 12:25 p.m., the MDS (minimum data set) Nurse#1 indicated the February 2019's care plan meeting was rescheduled at the request of Resident #46's	F 657	#46 plan of care was updated to reflect appropriate problems, goals, and interventions. Address the facility will identify other residents having the potential to be affected by the same deficient practice: •All residents have the potential for: 1) delayed care plan meetings, 2) interventions and revisions not being included on the plan of care or updated in a timely manner. Social Services Director will continue to mail meeting invitations to Resident Representatives. Upon next MDS Assessment, care plans will be reviewed by the IDT. •The IDT (Interdisciplinary Team) were re-educated by the Management Company's Director of Clinical Reimbursement on 4/30/19 as to the purpose and process of developing person- centered plans of care and the importance of keeping the problems, goals, and interventions up-to-date in order to reflect the current status of the resident, in addition to the value and requirement of holding regularly scheduled Care Plan meetings or to reschedule a missed meeting as soon as practical. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur •A member of the facility MDS team will attend the weekly meetings applicable to residents' care (e.g. wounds, weights, accident/incident, etc.) and update the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 16 Responsible Party and again due to the illness of the facility's Social Worker. On 4/12/19 at 12:30 p.m., MDS Nurse#1 stated that residents' care plans were updated after events such as an elopement, but any of the nursing staff could have updated the care plan. She also stated the resident had a communication board, but if he no longer used it, it should have been removed from the care plan. During an interview on 4/12/19 at 10:58 a.m., the Director of Nursing indicated it was the responsibility of the MDS nurse to attend and update the residents' care plans.	F 657	residents' plan of care as needed at the time of the meeting and developed intervention or discontinue interventions no longer be utilized. •IDT members will meet weekly to review care plans as required by the MDS assessment schedule and/or care plan goals. Residents and/or resident representative will be invited to attend quarterly care plan meetings Indicate how the facility plans to monitor its performance to make sure that solutions are sustained •50% of resident's discussed in the weekly meetings (see list above) will be audited by a sister facility MDS Coordinator on a weekly basis X 4 weeks, and as needed. •Results of audits will be brought to the morning facility administrative meeting, where QAA members are present, by a MDS Team representative weekly X 4weeks. Any non-compliance will be corrected at the time of discovery. •Results of audits will continue to be brought by a MDS Team representative to the facility monthly QAA meeting x 3 months, and as needed. •All discussion by QAA committee members will be recorded in the meeting minutes to include but not limited to continuing with stated plan or to identify any needed revisions. •Any revision to the above state plan will require re-inservicing of involved staff by the Management Team Director of Clinical Reimbursement/designee and for the monitoring to begin again at 3(a) and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 17	F 657	continue as outlined above. The Executive Director is responsible for the implementation of this plan.	
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, the facility failed to discard a piston irrigation syringe for enteral tube feeding flushes according to manufacturer ' s instructions for 1 of 1 residents reviewed for enteral tube feeding (Resident #78). Findings included:	F 693	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice •The piston irrigation syringe for resident #78 was disposed of on 4/10/19. •A supply of single use piston irrigation syringes were placed in Resident #78’s	5/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 18 A review of the policy for enteral tube feeding via syringe with a revision date of 2015 read, in part, "Clean reusable equipment according to the manufacturer ' s instructions". The manufacturer ' s instructions printed on the factory sealed plastic bag for a piston irrigation syringe were reviewed and the instructions read to discard the piston irrigation syringe after a single use. Resident #78 was admitted to the facility on 12/18/2018 with diagnoses to include respiratory failure, anoxic brain damage and epilepsy. A review of the physician orders for Resident #78 revealed an order dated 2/17/2019 for 150 ml water flushes for the feeding tube four times per day. The quarterly Minimum Data Set (MDS) assessment dated 3/15/2019 assessed Resident #78 to be severely cognitively impaired and he required total one-person assistance for all eating activities. The MDS coded Resident #78 to receive 51% or more of his calories through the enteral feeding tube and 501 milliliters (ml) or more of fluid through the enteral feeding tube per day. The feeding tube flush was observed on 4/10/2019 at 12:27 PM. Nurse #4 was observed administering 150 ml of water to Resident #78. The nurse completed the tube feeding flush and returned the piston irrigation syringe to a plastic bag and placed it on the resident ' s nightstand. The plastic bag was dated 4/10/2019 at 12:25 PM.	F 693	room for use. Address the facility will identify other residents having the potential to be affected by the same deficient practice: •All residents receiving nutrition/hydration by means of enteral feedings have the potential to be a risk. •All residents receiving nutrition/hydration by means of enteral feedings were reviewed and all piston irrigation syringes were replaced with a supply of single use piston irrigation syringes. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur •Licensed nurses were inserviced by the facility Staff Development Coordinator (SDC) on 4/10/19 with regards to the supply placement and use of single use piston irrigation syringes when flushing enteral tubes. Any nurse not in attendance on 4/10/19 is to be inserviced before the beginning of their next scheduled and all inservicing with regards to this topic to be completed on/before 5/10/19. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained •All residents with enteral tubes will be audited by the Director of Nursing Services (DNS)/ designee weekly X 4 weeks, and then monthly for 3 months and as needed, for proper use/disposal of piston irrigation syringes. Any non-compliance will be corrected as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 693	Continued From page 19 Nurse #4 was interviewed on 4/10/2019 at 12:27 PM. The nurse reported the piston irrigation syringe was used for a 24-hour period for any resident with an enteral tube feeding. The nurse went on to explain the syringe was stored in the plastic bag in the resident ' s room and used for water flushes and the administration of nutrition for Resident #78. An interview was conducted with the Staff Development Coordinator (SDC) on 4/11/2019 at 3:04 PM. The SDC reported the piston irrigation syringe used for water flushes and nutrition for enteral feeding tubes was changed every 24 hours at 11:00 PM by the nurse. The SDC stated she was not aware the piston irrigation syringe was single use. The Director of Nursing (DON) was interviewed on 4/11/2019 at 3:16 PM. The DON reported the manufacturer ' s instructions for the piston irrigation syringe were to discard after each use. The DON reported she was not aware the piston irrigation syringes were single use and she would in-service the staff to discard after each enteral tube water flush or the administration of nutrition. The Director of Clinical Operations was interviewed on 4/12/2019 at 1:32 PM and she reported it was her expectation that staff maintained resident safety by following manufacturer ' s instructions on the use of equipment.	F 693	found. •Results of audit will be brought to the morning administrative meeting, where QAA members are present, by the DNS/designee weekly X 4 weeks, and as needed for discussion of compliance. •Results of audit will be brought to the facility QAA monthly meeting by the DNS/designee monthly X3, and as needed until compliance can be maintained. •All discussion by QAA committee members will be recorded in the meeting minutes to include but not limited to continuing with stated plan or to identify any needed revisions. •Any revision to the above state plan will require re-inservicing of involved staff by the DNS/designee and for the monitoring to begin again at 3(a) and continue as outlined above. The Executive Director is responsible for the implementation of this plan.	
F 791 SS=D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services	F 791		5/10/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 20 The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for	F 791		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 21 reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to provide dental services for 1 of 2 residents reviewed for dental services (Resident #33). Findings included: Resident #33 was admitted to the facility 12/13/2018 with diagnoses to include pulmonary disease, congestive heart failure and gout. A review of the admission Minimum Data Set (MDS) assessment dated 12/19/2018 assessed Resident #33 to be cognitively intact without behaviors or rejection of care. The Oral/Dental Status section of the MDS was reviewed and revealed no obvious or likely cavities, no loose natural teeth, no mouth or facial pain and no discomfort or difficulty chewing. The medical record was reviewed and no orders or referral for dental care or a dentist assessment were noted. Resident #33 was observed on 4/9/2019 at 11:25 AM. Resident #33 was missing all teeth on his top jaw and had darkened and pitted teeth on the bottom jaw. An interview was conducted with Resident #33 on 4/9/2019 at 11:25 AM. He reported he had not been offered dental services at the facility. Resident #33 was interviewed on 4/11/2019 at 4:40 PM and he reported he had mouth pain on the left side of the lower jaw and only had 6 teeth, 3 on each side of the lower jaw. He further	F 791	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice •Resident #33 was seen by the dentist on 5/2/19. Oral surgery was recommended to remove all remaining teeth and then complete upper and lower dentures. Appointment with an oral surgeon is scheduled for 5/21/19. Resident remains on a regular diet with a recent weight gain of 4.6 lbs in the last month. Address the facility will identify other residents having the potential to be affected by the same deficient practice: •Oral Observation Questionnaire, to include condition of teeth and gums as well as any oral or facial pain, was completed on all residents from 5/1/19 to 5/7/19. Care plans will be reviewed and updated. Residents identified with dental issues or having oral/facial pain will be referred to speech therapy for a chewing/swallowing evaluation and referred for dental services/consultation by 5/10/19. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur •Oral Observation Questionnaire will be added to the admission packet to be completed on all new admission and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 22 reported he was able to chew food by avoiding chewing on the left side. MDS Nurse #1 was interviewed on 4/12/2019 at 11:56 AM and she reported she visited with Resident #33 every day and he had not complained of mouth pain to her and she had not noticed his missing teeth or tooth decay. MDS Nurse #1 further reported she had not completed Resident #33 ' s admission MDS and the nurse who did was no longer working at the facility. The Director of Clinical Operations was interviewed on 4/12/2019 at 1:32 PM and she reported it was her expectation the facility identified dental issues and provided services as appropriate.	F 791	readmissions and as needed. Residents identified with dental issues or having oral/facial pain will be referred to speech therapy for a chewing/swallowing evaluation and referred for dental services/consultation. •Licensed nurses will be in-serviced on the use of the Oral Observation Questionnaire by 5/10/19. Any nurse not in-serviced by 5/10/19 will be educated prior to their next shift. •CNAs were in-serviced regarding the STOP and WATCH form in order to communicate mouth/gum issues to nurses. •Social Services Director will be monitor the scheduling of any dental consults needed. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained •IDT will review the Oral Observation Questionnaires from new admission/readmissions to identify residents with dental issues or having oral/facial pain during the morning meetings for 4 weeks. •STOP and WATCH forms will be reviewed during the morning meeting. •Audit Compliance will be discussed weekly by the Social Service Director/designee during morning administration meetings where the Quality Assurance (QA) Committee members attend, X 4 weeks, and as needed. •Results of audits will be presented to the facility QA committee by the Social Service Director/designee monthly x3 and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345391	A. BUILDING _____ B. WING _____	C 04/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H	1131 NORTH CHURCH STREET GREENSBORO, NC 27401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 791	Continued From page 23	F 791	then quarterly thereafter, and as needed. All discussions, revisions to plan, and additional in-servicing will be noted in the QA Committee Meeting Minutes. The Social Services Director is responsible for the implementation of this plan.	